State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
DIANA M. BONTÁ, R.N., Dr. P.H.
Director

ARNOLD SCHWARZENEGGER
Governor

vember 17, 2003

TO: INTERESTED PARTIES

SUBJECT: FINAL GUIDANCE FOR APPLYING FOR HRSA COOPERATIVE AGREEMENT LOCAL FUNDING

The Centers for Disease Control and Prevention (CDC) provides states with funding via cooperative agreements to upgrade state and local public health jurisdictions' preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. Similarly, the Health Resources and Services Administration (HRSA) provides states with funding via cooperative agreements for hospital and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies. To ensure that all preparedness activities are coordinated and integrated at the state and local levels, the CDC and HRSA cooperative agreements have several cross-cutting activities. In addition, the CDC and HRSA bioterrorism preparedness cooperative agreements for 2003 require that the California Department of Health Services (CDHS) establish a joint advisory committee (JAC) to advise CDHS on the administration of the two agreements. The JAC comprises individuals from across California who represent a wide variety of entities including state agencies, local health departments, hospitals, clinics, emergency services agencies, and poison control centers.

CDHS will make available for local funding approximately $23.6 million of the $38.8 million HRSA funds awarded to California for 2003. Based on recommendations by the JAC, CDHS provides the attached final guidance for applying for the local assistance portion of the HRSA funds.

CDHS recognizes that local planning groups need sufficient time to assess local needs and develop the funding application. Thus, we encourage local health jurisdictions to convene a local planning group and begin work on the local funding application as soon as possible. As noted in the guidance, local jurisdictions must submit a letter of intent to apply by December 19, 2003. Completed applications are due January 30, 2004.

Jean Iacino
HRSA Cooperative Agreement Coordinator

2003 HRSA Cooperative Agreement Local Funding Guidance

The Health Resources and Services Administration (HRSA) provides states with funding via cooperative agreements for the National Bioterrorism Hospital Preparedness Program. The mission of the National Bioterrorism Hospital Preparedness Program is to ready hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies.

Congress authorized a continuing response to bioterrorism and other public health emergencies in June 2002. As part of this initiative, the Health Resources and Services Administration (HRSA) awarded funds to states for developing and implementing regional plans to improve the capacity of the health care system, including hospitals, emergency departments, outpatient facilities, emergency medical services (EMS) systems, and poison control centers, to respond to incidents requiring mass immunization, isolation, decontamination, diagnosis and treatment, in the aftermath of terrorism or other public health emergencies.

Purpose

The purpose of this cooperative agreement program is to build upon the planning, infrastructure development, and initial implementation that began in FY 2002, to continue to upgrade the preparedness of the Nation's health care system to respond to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. This will also allow the health care system to become more prepared to deal with non-terrorist epidemics of rare diseases, exposures to chemical toxins and radiological materials, and mass casualties due to explosions. The prime focus will be to develop, implement, and intensify regional terrorism preparedness plans and protocols for hospitals, outpatient facilities, EMS systems (both freestanding and fire-based), and poison control centers in collaborative statewide or regional models. Integration of the health care system plans with the public health department response is critical. The FY 2003 cooperative agreements will perpetuate successful FY 2002 bioterrorism preparedness activities based on needs assessments begun then. It will also include planning and implementation of new or expanded activities designed to prepare the regional health care systems for incidents of terrorism or other public health emergencies.

The goal of the cooperative agreement is to upgrade the ability of health care entities to respond to terrorist incidents; develop a multi-tiered system in which these entities are prepared to triage, isolate, diagnose, treat and refer multiple victims to identified centers of excellence; and develop regional consortia to pool limited funding to accomplish these goals. California is required to allocate most of these funds to hospitals, emergency medical systems, poison control centers, community health centers, rural health clinics, federally qualified health centers, tribally-owned health care facilities serving American Indians and Alaska Natives,

and other outpatient facilities that serve as vital points of entry into the health care system.

Funding
HRSA awarded California $38.8 million for Year 2 of the cooperative agreement, September 1, 2003 – August 31, 2004. (Los Angeles County has its own cooperative agreement funding from HRSA and will not share in the $38.8 million.) CDHS proposes to allocate approximately $23.6 million of these funds as local assistance, via procedures recommended by a Joint Advisory Committee (JAC) convened to advise CDHS on both the Centers for Disease Control and Prevention (CDC) and HRSA bioterrorism cooperative agreements. Based on the JAC's recommendations, CDHS will allocate the local funding on a formula basis, with each county receiving a base allocation of $85,000 plus additional funding based on population. Appendix A displays the amount of each county's total allocation. Local jurisdictions have the option of forming coalitions and pooling their allocations.

Of the total amount available for local funding, CDHS will set aside up to $1 million for demonstration or regional projects. The total amount allocated for such projects, while not exceeding $1 million, will be determined by the amount requested via applications and the merits of those applications. (CDHS is still developing guidance for these projects).

Who Can Apply
In order to satisfy HRSA requirements for direct funding, all of the local funding allocation must go to hospitals, outpatient facilities, and EMS systems through written agreements or purchase orders. However, under current law, absent a competitive bidding process, CDHS is only able to contract directly with local health jurisdictions or local emergency medical services agencies (LEMSAs).

Local jurisdictions or coalitions of jurisdictions must convene a planning group to develop and submit an application to CDHS outlining how the jurisdiction plans to spend the allocated funds. Local jurisdictions forming a coalition should submit a single application for their pooled allocation.

The local health jurisdiction will have the first right of refusal to be both the convener of the local planning group and the fiscal agent for the local funding.

The convener of the local planning group will:
- set meeting dates, times, and locations;
- set agendas;
- invite, at a minimum, a local health jurisdiction representative, a hospital representative, a clinic representative, and a LEMSA representative, and other interested parties to participate in the planning group;
- chair the meetings; and

- submit a letter of intent to apply for HRSA funds (see Appendix B for a template)

The fiscal agent will:

- accept funds on behalf of the jurisdiction
- disburse funds to hospitals, clinics, and other eligible recipients via contracts or memoranda of understanding
- track and report expenditures by critical benchmark

Each local jurisdiction or coalition application must be signed by the local health jurisdiction, a hospital representative, a clinic representative, and a LEMSA representative. The local planning group will decide which individuals will represent each required signatory. Hospitals, EMS systems, and outpatient facilities should work with the local planning group to request funding through this program. According to the HRSA cooperative agreement guidance, "outpatient facilities" include community health centers, rural health clinics, federally qualified health centers, tribally-owned health care facilities serving American Indians and Alaska Natives, and other outpatient facilities that serve as vital points of entry into the health care system. For the purpose of this application, local jurisdictions or coalitions should give preference to funding clinics licensed by CDHS prior to considering other types of clinics or outpatient facilities. CDHS encourages broad membership on the planning group that prepares the application. In addition to the four required signatories, planning groups should consider including representatives of the following entities, if feasible and appropriate to local circumstances:

- first responders, including law enforcement, fire, public and private ambulance providers, metropolitan medical response system (MMRS), hazmat teams
- local emergency management
- county bioterrorism coordinators
- mental health programs
- private sector health care providers
- poison control
- regional hospital councils/associations
- county hospital associations
- regional clinic associations
- maternal and child health programs
- universities
- county medical societies
- tribal health programs
- Veterans Health Administration

Administrative Costs
As noted above, the entire amount of the local allocation must be provided directly to hospitals, outpatient facilities, and emergency medical services systems, via written agreements or purchase orders, for addressing the critical benchmarks described below. However, CDHS will pay administrative costs of up to five percent to the fiscal agent for each local jurisdiction or coalition of jurisdictions. The administrative costs will be based on the amount of the local allocation that the fiscal agent administers to the final recipients. CDHS will not pay administrative costs on that portion of the local allocation that is used to purchase equipment or supplies via the single CDHS purchase order (described below) or any other portion of the local funds for which CDHS may contract directly. CDHS will not pay administrative costs for convening the local planning group.

Accountability
To ensure that all of the local funding reaches hospitals, outpatient facilities, and EMS systems, CDHS will require progress and cost expenditure reports from the fiscal agent. Please be prepared to describe the extent to which activities have been completed in future progress reports. Expenditure reports must show spending by critical benchmark. All expenditures must be auditable. In accordance with federal guidelines for the CDC cooperative agreement for bioterrorism funds, CDHS will require each local funding recipient to permit independent auditors to have access to the recipient's records and financial statements.

Deadlines
Local jurisdictions or coalitions of jurisdictions must submit to CDHS by December 19, 2003 a letter of intent to apply for the local funding. If a fiscal agent has not yet been determined, you may still submit the letter of intent, with the fiscal agent listed as "TBD." If the local health jurisdiction refuses fiscal agency, please note that on the letter of intent.

Local jurisdictions or coalitions of jurisdictions must file an application with CDHS as soon as feasible after receipt of this announcement, but no later than January 30, 2004.

Applications will be reviewed by CDHS. For applications that meet the review criteria, CDHS will notify grantees by February 27, 2004.

Application Requirements
Applications must use the following forms supplied in Appendix C:

Application Cover Sheet

Application Check List

Certification of Collaboration (signed by all four required signatories)

Application Narrative

Budget Spreadsheets (for each critical benchmark; separate Excel file)

Certifications of Non-Supplantation (signed by each funding recipient)

Local jurisdiction or coalition applications must address each of the following critical benchmarks found in the HRSA cooperative agreement guidance (ftp://ftp.hrsa.gov/hrsa/bioterror/bhppguidance.pdf):

- Benchmark 2-1
- Benchmark 2-5
- Benchmark 2-6
- Benchmark 2-7
- Benchmark 2-10
- Benchmark 6

In addition to the required benchmarks, local jurisdiction or coalition applications may use up to ten percent of their formula allocations to address other HRSA benchmarks, according to demonstrated local need. These other benchmarks may be undertaken only after the required critical benchmarks have been addressed. CDHS will evaluate proposals on non-required benchmarks to ensure that the proposed local activities do not duplicate or conflict with statewide activities on these benchmarks.

If the local application requests no funding for one or more of the above benchmarks, the application must demonstrate how that benchmark has already been achieved at the local level.

With the exception of Benchmark 2-1, the above benchmarks will be addressed exclusively at the local level. For Benchmark 2-1, CDHS will also contract with EMSA for some activities. However, local applications must also address Benchmark 2-1. See Appendix D for a description of the proposed EMSA funding and activities for this benchmark.

CDHS has addressed all other HRSA critical benchmarks on a statewide basis with other portions of the cooperative agreement funding.

For each critical benchmark, the application must provide a brief proposal for addressing the benchmark and a proposed budget using the budget templates provided in an accompanying Excel file. Funds must be used to supplement and not supplant the non-federal funds that would otherwise be made available for funded activities. Applications must include a signed certification against supplanting from **each** entity that will receive HRSA funds and/or equipment and

supplies purchased with HRSA funds. A non-supplantation certification template is attached as part of Appendix C.

Requests to purchase equipment and supplies must use the optional purchase list developed in Year 1. See Appendix E for a listing of the equipment and supplies approved for purchase during Year 1 of the HRSA cooperative agreement. CDHS will refer requests for items not represented on the Year 1 optional purchase list to a subcommittee of the JAC to recommend an appropriate item to become the standard.

CDHS will use the process employed by EMSA in Year 1 of the grant to purchase equipment and supplies via a single contract with the Department of General Services. This method ensures standardization of equipment and supplies, and also lower costs, including a sales tax exemption.

Critical Benchmarks to Be Addressed by Local Funding

Each application should include a narrative and a budget proposal addressing each of the following critical benchmarks. In addressing each benchmark, the local planning group should focus on activities that complement, but do not duplicate, activities undertaken by the local health jurisdiction with funding from the CDC bioterrorism cooperative agreement.

Critical Benchmark #2-1, Hospital Bed Capacity: *Establish a system that allows the triage, treatment, and disposition of 500 adult and pediatric patients per 1,000,000 population (or no fewer than 500 patients per awardee jurisdiction), with acute illness or trauma requiring hospitalization from a biological, chemical, radiological, or explosive terrorist incident.*

This system must address all components of the health care system (critical care, inpatient, outpatient and prehospital). Under the authorizing legislation, priority must be given to biological events before using these funds for chemical, radiological, or explosive incident planning. Applicants should consider the need to provide facilities for triaging large numbers of contagious patients before they enter health care facilities. In addition, due to the emergence of the severe acute respiratory syndrome (SARS) virus as a potential bioterrorist agent, applications should consider the need for adequate numbers of ventilators, oxygen, and trained respiratory therapists.

The application should address not only enhancing the surge capacity of individual hospitals, EMS systems, and outpatient facilities, but also fostering mutual aid agreements among them. Because biological events will not necessarily respect geographic boundaries, where appropriate, applications should address how local health jurisdictions and hospitals will collaborate and form multi-jurisdictional regional work plans for mutual aid and cooperation during a disaster response. Additionally, recognizing that many patients may come from

rural areas served by referral centers in metropolitan areas, urban planning must include the surrounding areas likely to impact municipal resources. Conversely, in the event of an urban terrorist attack, experience indicates that many people will evacuate to a more rural area. Consequently, the sudden influx of potential patients into rural facilities should be addressed in the application.

In addition to developing additional on-site capacity using large shelter tents such as those provided in Year 1, applicants should also consider plans for the transfer of non-acute patients to alternate facilities to free in-patient beds to accommodate a surge during a disaster. Off-site options for increasing bed capacity might include mobile facilities, temporary facilities appropriate to an austere environment, large convention halls, armories, and fair grounds. In considering these options, applicants are encouraged to plan for facilities that would accommodate isolation of contagious patients. Applicants should also consider contingency planning for staffing these facilities, including infection control expertise, and security needs. Applicants should address how they will ensure that staff has received adequate training and is aware of infection control practices and guidelines.

The application should address the operational and physical needs of special populations such as people with disabilities, pregnant women, children, the elderly, and those with special health care needs. The application should account for the translation needs of major non-English speaking groups in the awardee jurisdiction, including locally appropriate means for communicating with the hearing impaired. The application may include provisions for the decontamination and final disposition of human remains, and associated forensic procedures.

Critical Benchmark #2-5, Pharmaceutical Caches: *Establish local or regional systems whereby pharmacies based in hospitals or otherwise participating in the local or regional health care response plan have surge capacity to provide pertinent pharmaceuticals in response to bioterrorism or other public health emergencies.*

The surge cache should be within the stock rotational capacity of the participating pharmacies, to prevent shelf-life expiration of the medications, vaccines, and supplies. The application should explain how these systems complement the Strategic National Stockpile (SNS). Contingency plans for pharmaceuticals needed in chemical and radiological terrorism preparedness may be considered after biological terrorism preparedness is fully addressed as required under the authorizing legislation.

The application may provide for distributing prophylactic medications and antidotes to emergency response personnel in hospitals, clinics, and emergency medical services systems, and their families, within 12 hours. CDHS has the primary role in this effort.

Recognizing that a Federal response is secondary to a local jurisdiction's ability to respond to a disaster, pharmacies participating in the regional health care response plan should optimize their capacity to provide pertinent pharmaceuticals for an immediate response before the SNS may be realistically available. Consistent with concerns that have been expressed about potential overuse of medical treatments for biological or chemical exposures, adult and pediatric treatment protocols must be consistent with generally accepted clinical recommendations, such as those promulgated by CDC and appropriate professional organizations. When planning for a response to likely terrorist threats, priority should be given to the following agents thought to be credible threats:

- Viruses: smallpox, hemorrhagic fevers, and equine encephalitides
- Bacteria: anthrax, plague, brucellosis, Q fever, and tularemia
- Toxins: ricin, botulinum, staphylococcal enterotoxin-B, and T-2 mycotoxin
- Nerve agents: organophosphates, sarin, tabun, soman, VX
- Respiratory agents: cyanide, mustard agent
- Toxic Industrial Chemicals: hydrofluoric acid, isocyanates, methyl bromide, ammonia, chlorine
- Radiation illness: acute manifestations, delayed complications

Purchase of medications and vaccines using HRSA funds should be limited to instances where stock rotation by participating pharmacies in their normal course of business is possible to avoid product expiration. In addition, applicants should establish mechanisms to sustain and/or replenish the caches after initial funding.

Critical Benchmark #2-6, Personal Protection: *Ensure adequate personal protective equipment (PPE) to protect 250 or more health care personnel per 1,000,000 population in urban areas, and 125 or more health care personnel per 1,000,000 population in rural areas, during a biological, chemical or radiological incident.*

Critical Benchmark #2-7, Decontamination: *Ensure that adequate portable or fixed decontamination systems exist for managing 500 adult and pediatric patients and health care workers per 1,000,000 population, who have been exposed to biological, chemical, or radiological agents.*

The application should assess the availability of personal protective and decontamination equipment in the local jurisdiction and determine what unmet needs exist in order to adequately protect health care workers and emergency medical responders in a terrorist incident. Applicants should determine how PPE and decontamination facilities will be allocated between rural and metropolitan hospitals, to address possible contamination in both types of venue. Hospitals and other health care entities may be targeted for capital improvements for facilities capable of safe and effective decontamination of large numbers of adult

and pediatric patients with particulate biological, chemical or radiological exposures. Any such capital improvements must be directly incident to the installation of equipment to enhance preparedness for and response to such public health emergencies. Mobile decontamination facilities and supply caches may be funded to maximize benefit and cost-effectiveness. Equipment purchased under this benchmark must be interoperable with any equipment purchased with funds from the federal Department of Homeland Security's State Homeland Security Grant Program (SHSGP) for first responders.

Any application for PPE or decontamination purchases must be consistent with the optional purchase list developed in Year 1 and listed in Appendix C. Local jurisdictions or coalitions should contact CDHS if they need more information regarding Year 1 purchases within the jurisdiction. CDHS will refer requests for items not represented on the Year 1 optional purchase list to a subcommittee of the JAC to recommend an appropriate item to become the standard. Applications should address plans for fit testing, storage, maintenance, and training staff on the use of any PPE and decontamination equipment purchased.

Critical Benchmark #2-10, Communications and Information Technology: *Establish a secure and redundant communications system that ensures connectivity during a terrorist incident between health care facilities and state and local health departments.*

Describe steps taken to ensure the vertical and horizontal connectivity and interoperability of various information technology systems with those of health departments, hospitals, emergency medical services, emergency management agencies, public safety agencies, neighboring jurisdictions and state public health officials. The system should include: a) Internet connectivity; b) electronic mail for notification of alerts and other critical communications; and c) radio backup for land-line and cellular phone systems that may be compromised during a terrorist incident. There should be a discussion of local and State communications capabilities available to hospitals, clinics, and EMS systems. Equipment purchased under this priority area must be interoperable with any equipment purchased with funds from the Department of Homeland Security's State Homeland Security Grant Program (SHSGP) for first responders and with equipment purchased under Year 1 of the HRSA cooperative agreement. Funding proposals for information technology must be consistent with the approach and technical specifications contained in the Appendix to the FY 2003 CDC guidance on the Public Health Preparedness Program. Proposals under the HRSA cooperative agreement to enhance health care system communication abilities must be clearly distinguished from similar proposals that respond to the CDC guidance addressing health department preparedness.

CDHS and the JAC will work toward developing a statewide information technology approach to linking communications systems. Such linkage will not be achieved this year but rather in future years of the cooperative agreement.

Bearing this in mind, local applications should address communications needs based on the following priorities:

- ensuring Internet access for hospitals and clinics,
- building on Year 1 hospital communication systems purchases,
- ensuring that hospitals and clinics are linked with the local health department to receive California Health Alert Network (CAHAN) alerts, and
- planning for future interfaces between hospital and clinic systems and CAHAN.

Critical Benchmark #6,* Terrorism Preparedness Exercises*: *As part of a written evaluation strategy of the applicants program, conduct at least one bioterrorism disaster exercise in the jurisdiction during FY 2003 that covers a large-scale epidemic scenario affecting both adults and children.*

The biological disaster exercise must be of sufficient intensity to challenge the community's management and response operations during the exercise, in a way similar to what would be expected during an actual biological terrorist incident. CDHS encourages regional approaches to exercises. The exercise process must be documented in an after-action report to be sent to CDHS, and must include an evaluation component that captures strengths and weaknesses in a way that promotes system improvement. Other terrorism disaster exercises are encouraged, that cover large-scale chemical, radiological, and explosive scenarios. These exercises may be of similar intensity to that described above, or may be tabletop exercises designed as preliminary tests of the utility of the work plan. Applicants must participate in at least one local, regional, or statewide bioterrorism exercise and should consider scenarios that include distributing medications to a large number of individuals. See http://www.oes.ca.gov/exerciseschedule.nsf/Course%20and%20Exercise%20Schedule?OpenView&Start=1 to view the California Master Exercise Schedule.

Optional Benchmark #2-9, Trauma and Burn Care Capacity: *For applicants choosing to fund this section, enhance trauma care capacity to be able to respond to a mass casualty incident due to terrorism. This plan should ensure the capability of providing trauma care to at least 50 severely injured adult and pediatric patients per million of population per day.*

Applications do not have to address this benchmark. Applications should address this optional benchmark only after all the above critical benchmarks have been addressed.

The application should take into account the need for general surgeons, pediatric surgeons, trauma surgeons, neurosurgeons, orthopedic surgeons, other surgical specialists, anesthesiologists, critical care specialists, nurses and ancillary health care personnel in implementing an effective surgical and burn unit terrorism

response plan. Resources may include, but are not limited to, metropolitan medical response systems, disaster medical assistance teams, and mobile surgical response teams. Regional plans may be proposed for upgrading equipment or facilities to accommodate mass surgical and burn casualties due to a terrorist incident.

Appendix A

HRSA LOCAL ASSISTANCE BIOTERRORISM FUNDING ALLOCATION SEPTEMBER 1, 2003 - AUGUST 31, 2004

COUNTY	POPULATION JAN 2003	PER CAP %	BASE ALLOCATION $85,000/County	PER CAP ALLOCATION	TOTAL HRSA LOCAL ASSISTANCE ALLOCATION
ALAMEDA	1,496,200	5.842020%	$85,000	$1,094,210	$1,179,210
ALPINE	1,210	0.004725%	$85,000	$885	$85,885
AMADOR	36,500	0.142517%	$85,000	$26,693	$111,693
BUTTE	210,400	0.821522%	$85,000	$153,871	$238,871
CALAVERAS	42,450	0.165749%	$85,000	$31,045	$116,045
COLUSA	19,700	0.076920%	$85,000	$14,407	$99,407
CONTRA COSTA	994,900	3.884658%	$85,000	$727,596	$812,596
DEL NORTE	27,850	0.108742%	$85,000	$20,367	$105,367
EL DORADO	166,000	0.648159%	$85,000	$121,400	$206,400
FRESNO	841,400	3.285306%	$85,000	$615,338	$700,338
GLENN	27,050	0.105619%	$85,000	$19,782	$104,782
HUMBOLDT	128,300	0.500957%	$85,000	$93,829	$178,829
IMPERIAL	150,900	0.589200%	$85,000	$110,357	$195,357
INYO	18,350	0.071649%	$85,000	$13,420	$98,420
KERN	702,900	2.744523%	$85,000	$514,049	$599,049
KINGS	136,100	0.531412%	$85,000	$99,534	$184,534
LAKE	61,300	0.239350%	$85,000	$44,830	$129,830
LASSEN	34,950	0.136465%	$85,000	$25,560	$110,560
MADERA	131,200	0.512280%	$85,000	$95,950	$180,950
MARIN	250,400	0.977705%	$85,000	$183,124	$268,124
MARIPOSA	17,450	0.068135%	$85,000	$12,762	$97,762
MENDOCINO	88,200	0.344383%	$85,000	$64,503	$149,503
MERCED	225,100	0.878919%	$85,000	$164,622	$249,622
MODOC	9,325	0.036410%	$85,000	$6,820	$91,820
MONO	13,350	0.052126%	$85,000	$9,763	$94,763
MONTEREY	415,800	1.623521%	$85,000	$304,085	$389,085
NAPA	129,800	0.506813%	$85,000	$94,926	$179,926
NEVADA	95,700	0.373667%	$85,000	$69,988	$154,988
ORANGE	2,978,800	11.630938%	$85,000	$2,178,475	$2,263,475
PLACER	275,600	1.076100%	$85,000	$201,554	$286,554
PLUMAS	20,900	0.081606%	$85,000	$15,285	$100,285
RIVERSIDE	1,705,500	6.659247%	$85,000	$1,247,277	$1,332,277
SACRAMENTO	1,309,600	5.113427%	$85,000	$957,745	$1,042,745
SAN BENITO	56,300	0.219827%	$85,000	$41,174	$126,174
SAN BERNARDINO	1,833,000	7.157080%	$85,000	$1,340,521	$1,425,521
SAN DIEGO	2,961,600	11.563779%	$85,000	$2,165,896	$2,250,896
SAN FRANCISCO	791,600	3.090859%	$85,000	$578,918	$663,918
SAN JOAQUIN	613,500	2.395455%	$85,000	$448,669	$533,669
SAN LUIS OBISPO	256,300	1.000742%	$85,000	$187,439	$272,439
SAN MATEO	717,000	2.799578%	$85,000	$524,361	$609,361
SANTA BARBARA	410,300	1.602046%	$85,000	$300,063	$385,063
SANTA CLARA	1,729,900	6.754518%	$85,000	$1,265,121	$1,350,121
SANTA CRUZ	259,800	1.014408%	$85,000	$189,999	$274,999
SHASTA	172,000	0.671586%	$85,000	$125,788	$210,788
SIERRA	3,520	0.013744%	$85,000	$2,574	$87,574
SISKIYOU	44,400	0.173363%	$85,000	$32,471	$117,471
SOLANO	412,000	1.608683%	$85,000	$301,306	$386,306
SONOMA	472,700	1.845691%	$85,000	$345,698	$430,698
STANISLAUS	481,600	1.880442%	$85,000	$352,207	$437,207
SUTTER	83,200	0.324860%	$85,000	$60,846	$145,846
TEHAMA	57,700	0.225294%	$85,000	$42,198	$127,198
TRINITY	13,300	0.051931%	$85,000	$9,727	$94,727
TULARE	386,200	1.507946%	$85,000	$282,438	$367,438
TUOLUMNE	56,500	0.220608%	$85,000	$41,320	$126,320
VENTURA	791,300	3.089687%	$85,000	$578,698	$663,698
YOLO	181,300	0.707899%	$85,000	$132,589	$217,589
YUBA	62,800	0.245207%	$85,000	$45,927	$130,927
TOTALS	25,611,005	1.0000000	$4,845,000	$18,730,000	$23,575,000

Appendix B
Letter of Intent
2003 HRSA Cooperative Agreement Local Funding

Submit electronically, by December 19, 2003, to:
Jean Iacino, HRSA Cooperative Agreement Coordinator, California Department of Health Services, jiacino@dhs.ca.gov

The following jurisdiction(s) plan to submit a single application for 2003 HRSA Cooperative Agreement Local Funding:

Name of Jurisdiction(s):

The convener of the local planning group for this application will be:

Contact Name and Organization:

Address:

Telephone:

Email:

The fiscal agent for this application will be:

Contact Name and Organization:
(If a fiscal agent has not yet been determined, you may still submit the letter of intent, with the fiscal agent listed as "TBD." If the local health jurisdiction has refused fiscal agency, please note that also).

Address:

Telephone:

Email:

California Department of Health Services
Application for Health Resources and Services Administration
FY 2003 Cooperative Agreement Local Funding
Appendix C
Application Cover Sheet

Project Budget Period: September 1, 2003 – August 31, 2004

Jurisdictions Participating in This Application:

Maximum Amount Authorized (from Appendix A of the guidance*)*

$_____

Equipment/Supplies Amount Requested

$ _____

Other Direct Assistance Amount Requested

$ _____

Administrative Costs Requested (up to 5% of "Other Direct Assistance")

$ _____

Total Amount Requested

$_____

Application Fiscal Agent (County):

_____

Fiscal Agent Contact Information:

_____
Name/Title

_____
Authorized Agent Mailing Address

_____
City, State, Zip Code

_____
Telephone Number

_____
Email Address

California Department of Health Services
Application for Health Resources and Services Administration
FY 2003 Cooperative Agreement Local Funding
Appendix C
Application Checklist

The following items must be included with this grant application package:

☐ Application Cover Sheet

☐ Certificate of Collaboration (signed by all four required signatories)

☐ Application Narrative

☐ Budget Spreadsheets (for each critical benchmark)

☐ Certificates of Non-Supplantation (signed by each funding recipient)

California Department of Health Services
Application for Health Resources and Services Administration
FY 2003 Cooperative Agreement Local Funding
Appendix C
Certification of Collaboration

Each local jurisdiction or coalition application must be signed by the local health jurisdiction, a hospital representative, a clinic representative, and a LEMSA representative.

I hereby certify that the attached application addresses bioterrorism preparedness and response needs in the jurisdiction(s) represented in this application, as agreed upon via a collaborative planning process.

Local Health Jurisdiction Representative:

Name:_____

Title:_____

Agency:_____

Signature:_____

Clinic Representative:

Name:_____

Title:_____

Agency:_____

Signature:_____

Hospital Representative:

Name:_____

Title:_____

Agency:_____

Signature:_____

LEMSA Representative:

Name:_____

Title:_____

Agency:_____

Signature:_____

California Department of Health Services
Application for Health Resources and Services Administration
FY 2003 Cooperative Agreement Local Funding
Appendix C
Application Narrative Template

Please submit your narrative in the format below. The narrative should not exceed three pages per critical benchmark.

Critical Benchmark
List the critical benchmark being addressed.

Local Needs Assessment
Provide narrative of the local need related to the critical benchmark. Please cite data sources that support the needs assessment. Include a discussion of current capabilities in this area, including a discussion of supplies or equipment purchased relative to this benchmark during Year 1 of the HRSA Cooperative Agreement.

Priority
Provide narrative describing how this benchmark ranks as a local priority, relative to the other critical benchmarks addressed in the application. How did the local planning group determine this priority?

Proposal for HRSA Local Funding
Describe how much HRSA funding is requested for this benchmark. Clearly outline how this funding will be spent, including the specific entities that will receive funding and the amount and activities or equipment and supplies proposed for each entity. Describe how the funding will help the jurisdiction as a whole progress toward achieving the critical benchmark. How does the proposal contribute to regional preparedness? Can the jurisdiction accomplish the funded activities within the grant period?

Appendix C
Certification of Non-Supplantation

2003 HRSA Cooperative Agreement
National Bioterrorism Hospital Preparedness Program
Local Funding

(Name of Entity Receiving Funds and/or Equipment and Supplies)

I hereby certify that the above-named entity will not use HRSA Cooperative Agreement funds allocated by the California Department of Health Services (CDHS) to supplant funding for existing levels of service and that funds will only be used for the purposes specified in the local jurisdiction application for local funding approved by CDHS.

Signature:
Printed Name:
Title:
Phone:
Date:

Please return an original certification for each recipient of HRSA funds and/or equipment and supplies purchased with HRSA funds, with the funding application.

Appendix D

Hospital Bioterrorism Preparedness Program
Emergency Medical Services Authority Activities Related to Critical Benchmarks That Are Also Targeted for Local Funding

Allocation Area	Description	Dollars Allocated
Critical Benchmark 2-1	1. Update and revise Hospital Emergency Incident Command System (HEICS) Version III to incorporate weapons of mass destruction events into the structure of the system. 2. Develop a clinic Incident Command System (ICS) to enhance interoperability with hospital and community emergency management operations. 3. Develop and update training programs for HEICS and the clinic ICS, including instructor certification and training video. 4. Conduct regional training sessions for hospitals and clinics in the updated and newly developed systems.	$500,000
Critical Benchmark 2-1	1. Develop statewide guidelines, protocols and plans for establishment of field treatment sites (FTS; both hospital based and EMS/community-based). This has never been defined in California and needs clarification and guidelines. 2. Create a training program for local, regional and state providers on the FTS model.	$300,000
Critical Benchmark 2-9	1. Establish cache of medications for burn and trauma care and trauma care supplies and instruments. 2. Investigate mobile trauma units pre-positioned within the state to respond to an incident and augment trauma/burn care.	$500,000
Total		$1,300,000

Appendix E
Equipment, Supplies, and Medications Selected for Optional Facility Purchase Year 1

EMSA staff and the Hospital Bioterrorism Preparedness Planning Committee researched and selected these products as standard purchases in Year 1 of the HRSA cooperative agreement. The optional items were selected based on the results of the Statewide Bioterrorism Preparedness Assessment and meeting the mandates of the HRSA grant. Additional purchase of these types of products proposed in Year 2 must also be made from the EMSA-approved list. EMSA evaluated the products based on the following criteria:

- Standardization across the county and state, to facilitate interoperability and enhance regional response capacity
- OSHA, NIOSH or other regulatory agency approval
- Shelf life
- Ease of use
- Multiple use
- Cost

To view specific details for each item, visit the listed web site. Please note, the equipment and medications below were purchased from the Federal Prime Vendor Program and are therefore priced below State or retail purchases.

Personal Protective Equipment

3M Breathe Easy (BE) 10 Powered Air Purifying Respirator (PAPR) with Butyl Rubber Hood with lithium battery pack – NIOSH approved

http://products3.3m.com/catalog/us/en001/government/innovative_solutions/node_WCW9FKC329gs/root_GS3RBW6QFVgv/vroot_31S2JJ7584ge/bgel_0Z2X6C7WCCbl/gvel_B2T6KCNFS4gl/theme_us_innovativesolutions_3_0/command_AbcPageHandler/output_html

Approximate cost $710

Dupont Tychem CPF 3 Coveralls

http://www.personalprotection.dupont.com/protectiveapparel/products/chemicalprotection/tychemcpf3.html

Approximate cost $28.32

Don-it Post Decontamination Personal Privacy Kit

http://www.hazmatdge.com/c-don.htm

Approximate cost $13.68

Surge Capacity Tents and Accessories

TVI Casualty Management Shelter

www.tvicorp.com/index.cfm?fuseaction=product&prod_cat=2&prod_id=16

Approximate cost $11,812

Ramfan UB-20 Inline Heater

http://www.ramfan.com/ramfan/confine/con60.htm#ub20

Approximate cost $2,450

Portable Fluorescent Light Fixture

http://www.tvicorp.com/index.cfm?fuseaction=product&prod_cat=4&prod_id=34

Approximate cost $275

Honda EB 6500 Generator

http://www.hondapowerequipment.com/eb6500.htm

Approximate cost $3,055

Military Style Folding Cot

http://www.actiongear.com/cgi-bin/tame.exe/agcatalog/level4s.tam?xax=3318&M5COPY%2Ectx=26450&M5%2Ectx=26450&M2%5FDESC%2Ectx=Bivouac%20%2D%20Sleeping%20Bags%2C%20Shelters%2C%20Modular%20Sleep%20Systems%2C%20Bivy%20Bags&level3%2Ectx=results%2Etam&query%2Ectx=cot&backto=%2Fagcatalog%2Fresults%2Etam

Approximate cost $73.75

Decontamination Tents and Accessories

TVI 2-line Decontamination System

http://www.tvicorp.com/index.cfm?fuseaction=product&prod_cat=1&prod_id=1

Approximate cost $18,808

TVI Flash Water Heater SF-12 with Injector System

http://www.tvicorp.com/index.cfm?fuseaction=product&prod_cat=4&prod_id=23

The flash water heated was included in the pricing for the tent.

TVI Hand Sprayers

http://www.tvicorp.com/index.cfm?fuseaction=product&prod_cat=1&prod_id=1

The hand sprayers were included in the pricing for the tent.

Hospital Pharmaceutical Caches: This cache provides medications for 50 people for three days.

Bactrim DS, 300 tablets
Doxycycline 100 mg capsule, 300 capsules
Doxycycline 100 mg injection, 300 vials
Levofloxacin 500 mg tablet, 150 tablets
Amoxicillin 250 mg capsule, 450 capsules
Gentamycin 80 mg injection, 600 vials

Cost: $5571.75/cache